Personal Health History

Name **Home phone** **Work phone**

Address **City ,** **State,** **Zip**

Date of birth **Occupation** **email address**

Who referred you to this office? **Date of accident**

If you are in an auto accident please sign here to authorize insurance payments to be made directly to the doctor and to release medical information needed by your insurance company to process your claim.
Please note: your insurance company may not pay the full amount for your visits to this office. You are responsible for any outstanding balance not covered by your insurance.

Print Name **Signature** **Date**

List current medications and supplements

What is your current complaint?

How and when did this begin?

Do you suffer from any other conditions?

Have you had major surgery? Please describe what and when:

List any major accidents or falls:

Please mark any of the following that you currently have with a C, and any of the serious conditions that you have had in the past with a P.

- Headaches
- Fever
- Chills
- Night sweats
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Nervousness
- Loss of weight
- Allergies
- Wheezing
- Neuralgia
- Poor appetite
- Poor digestion
- Excessive hunger
- Belching or Gas
- Nausea
- Vomiting
- Vomiting blood
- Pain over stomach
- Constipation
- Diarrhea
- Colon trouble
- Hemorrhoids
- Liver trouble
- Jaundice
- Gall bladder trouble
- Pain in eyes
- Deafness
- Earache
- Ear noises
- Ear discharges
- Nasal obstruction
- Nose bleeds
- Hay fever
- Asthma
- Frequent colds
- Chronic cough
- Spitting blood
- Difficulty breathing
- Chest pain
- Frequent urination
- Painful urination
- Blood in urine
- Kidney infection
- Bed wetting
- Inability to control urine
- Prostrate trouble
- Hernia
- Swollen ankles
- Foot trouble
- High blood pressure
- Heart trouble
- Strokes
- Hives
- Skin rashes
- Numbness or pain in arms or hands
- Numbness or pain in legs or feet
- Sore throat

Questions for women only

- Irregular cycles
- Excessive flow
- Painful periods
- Hot flashes
- Severe cramps
- Vaginal discharge

Date of last pap smear

_____
month/ year

Have you had any of the following diseases?

- Appendicitis
- Pneumonia
- Rheumatic fever
- Polio
- Tuberculosis
- Whooping cough
- Anemia
- Measles
- Mumps
- Chicken pox
- Cancer
- Diabetes
- Goiter
- Heart disease
- Pleurisy
- Venereal infection
- Arthritis
- Epilepsy
- Eczema
- Psoriasis
- Psychological disorder

Habits

Smoking _____ packs per day

Drinking _____

Coffee _____ cups per day

Family History

	Diabetes	Heart	Kidney	Cancer
Mother				
Grandparents				
Father				
Siblings				

Crossman Chiropractic
Notice of Informed Consent

Doctors of Chiropractic, Medical Doctors and Physical therapists who use manual therapy techniques such as spinal adjustments and manipulations are required to advise patients that there is some risk associated with such treatment. In particular:

a. While rare, some patients have experienced muscle strain, ligamentous sprain and rib fracture following spinal adjustments or manipulation.

b. There have been reported cases of injury to the vertebral artery (blood vessel located in the neck) following adjustment or manipulation to the neck (cervical spine). Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment. The possibility of such injuries resulting from neck, spinal adjustment or manipulation are extremely rare.

c. There have been rare reported cases of disc injuries following neck or low back spinal adjustment or manipulation. However, scientific study has not supported that such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment or manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years. These reports and studies have demonstrated chiropractic treatment to be effective for spinal pain, headaches, and other similar symptoms. Chiropractic care may contribute to overall well being. The risk of injuries or complication from chiropractic treatment is substantially lower than that associated with other treatments, medications, and procedures given for the same symptoms.

Care at Crossman Chiropractic may involve: palpation (examination through touch) of the spine, head, legs, shoulders, arms, pelvis and adjacent muscles and ligaments. Testing of muscles and ligaments through the use of orthopedic tests are also part of the exam. Treatment may involve clinically focused massage (myofascial release), stretching and for some, spinal manipulation. All patients are fully clothed during the exam and treatment. Commonly employed hand positions include: the doctor placing his hand under the pelvis while patient is lying face up. Treatment is primarily focused on the muscles adjacent the spine, pelvis and neck. But may include the: arms, legs, buttocks, abdomen, shoulders, chest, throat, head and face.

I,_____ , acknowledge that I have discussed or have had the opportunity to discuss, with my chiropractor, the nature and purpose of my treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the treatments offered or recommended to me by Dr. Crossman including spinal adjustment and myofascial release therapy. I intend this consent to apply to my present and future chiropractic or physical therapy care.

_____

Patient Signature Date

_____

Witness Signature Date

Show me where it hurts

Mark these drawings according to where you hurt. If the back of the neck hurts, mark the drawing on the back of the neck, etc. If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

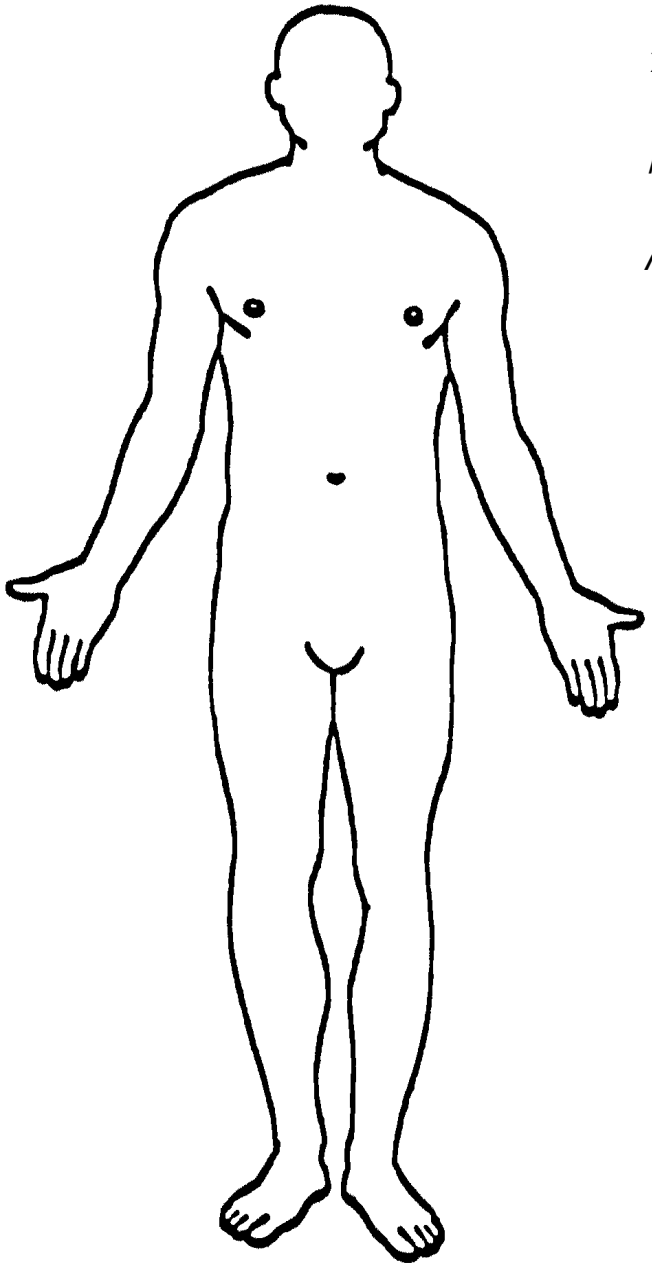
Numbness
= = = = =

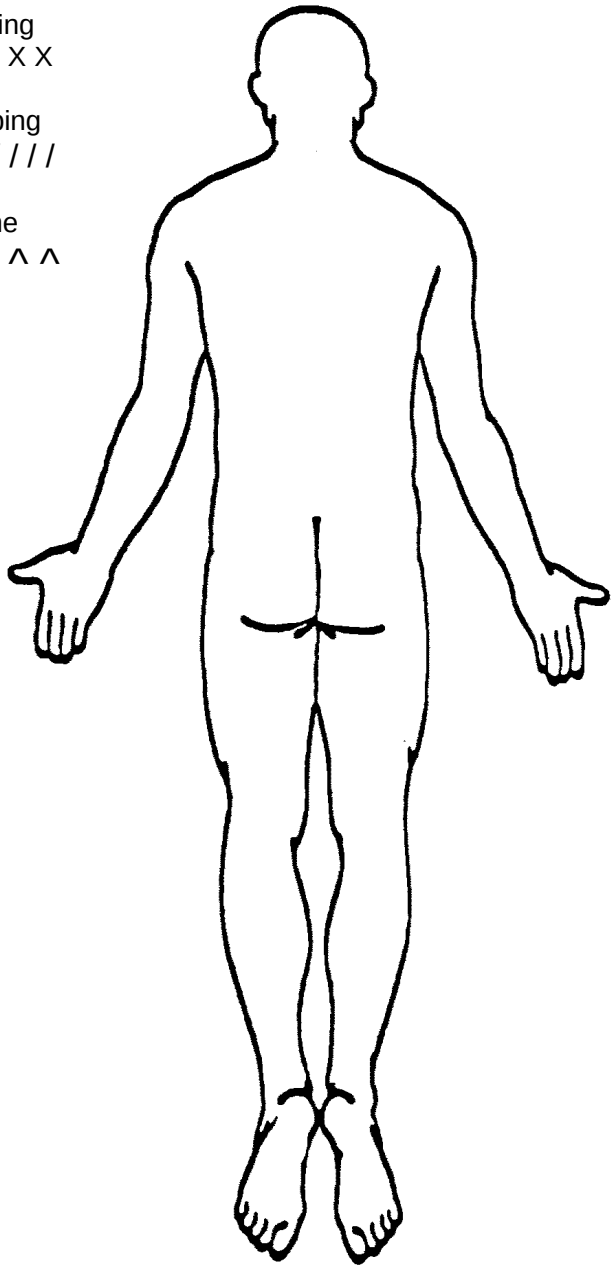
Pins and needles
O O O O O O O

Burning
X X X X X

Stabbing
/ / / / / / / /

Ache
^ ^ ^ ^ ^





Crossman Chiropractic Office

PRIVACY NOTICE TO PATIENTS THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties
for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and
health care operations of the Practice. The following are examples of the types of uses and/or disclosures of
your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

1. **Care** - In order to provide care to you, the Practice will provide your PHI to those health care professionals,
   whether on the Practice's staff or not, directly involved in your care so that they may understand your medical condition and needs and provide advice or treatment (i.e. your physician). For example, your physician may need to know how your condition is responding to the treatment provided by the Practice.

2. **Payment** - In order to get paid for some or all of the health care provided by the Practice, the Practice may
   provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide your health insurance
   carrier with information about health care services that you received from the Practice so that the Practice
   can be properly reimbursed.

3. **Health Care Operations** - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use
   your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

AUTHORIZATION NOT REQUIRED

The Practice may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

1. **De-identified Information** - Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.

2. **Business Associate** - To a business associate, which is someone who the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and health care operations (~ billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.

3. **Personal Representative** - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

4. **Public Health Activities** - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.

5. **Federal Drug Administration** - If required by the Food and Drug Administration to report adverse events,
product defects or problems or biological product deviations, or to track products, or to enable product recalls, repairs or replacements, or to conduct post marketing surveillance,

6. **Abuse, Neglect or Domestic Violence** - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm or if the Practice believes that you have
been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance
with the requirements of law, which may also involve notice to you of the disclosure.

7. **Health Oversight Activities** - Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.

8. **Judicial and Administrative Proceeding** - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

9. **Law Enforcement Purposes** - In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (1e., subpoena) or as required by law; (2) information for identification and location purposes <M., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.

10. **Coroner or Medical Examiner** - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.

11. **Organ, Eye or Tissue Donation** - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

12. **Research** - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board and the requirement that protocols must be followed.

13. **Avert a Threat to Health or Safety** - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

14. **Specialized Government Functions** - When the appropriate conditions apply, the Practice may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

15. **Inmates** - The Practice may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care

and treatment to you or is necessary for the health and safety of other individuals or inmates.

16. **Workers' Compensation** - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

17. **Disaster Relief Efforts** - The Practice may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.

18. **Required by Law** - If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization, which you may revoke at any time.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders. The reminder may be in the form of a letter or postcard. The Practice will try to minimize the amount of information contained in the reminder. The Practice may also contact you by phone and, if you are not available, the Practice will leave a message for you.

TREATMENT ALTERNATIVES/BENEFITS

The Practice may, from time to time, contact you about treatment alternatives, or other health benefits or services that may be of interest to you.

YOUR RIGHTS You have the right to:

1. Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

2. Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

3. Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

4. Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

5. Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason and support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.

6. Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and may not include the dates before April 14, 2003. The

request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12 month period will be free, but the Practice may charge you for the cost of providing additional lists in that same 12 month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

7. Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

8. Complain to the Practice, or to the Secretary of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Building, 200 Independence Avenue, S. W., Room 509F HHH Building, Washington, D.C. 20201. Or you may contact a regional office of the Office of Civil Rights, which can be found at www.hhs.gov/ocr/regmail.html. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. AU complaints must be in writing.

9. To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer: Gregory Crossman, D.C.

PRACTICE'SREQUIREMENTS

The Practice:

1. Is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice of the Practice's legal duties and privacy practices with respect to your PHI.
2. Is required to abide by the terms of this Privacy Notice.
3. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
4. Will not retaliate against you for making a complaint.
5. Must make a good faith effort to obtain from you an acknowledgement of receipt of this Notice.
6. Will post this Privacy Notice on the Practice's web site, if the Practice maintains a web site.
7. Will provide this Privacy Notice to you bye-mail if you so request. However, you also have the right to obtain a paper copy of this Privacy Notice.

EFFECTIVE DATE

This Notice is effective as of January 1, 2005

ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Practice's Privacy Notice.

_____

Name of Individual (Printed) Signature of Individual

_____

Date Signed